CONTRACT #14
RFS # 318.66-050

Department of Finance & Administration/Bureau of TennCare

VENDOR:
Tennessee Behavioral Health Inc.
(East Grand Region)

REQUEST: NON-COMPETITIVE AMENDMENT

RECEIVED

DEC 0 8 2005

FISCAL REVIEW

APPROVED
Commissioner of Finance & Administration Date:

Each of the request items below indicates specific information that must be individually detailed or addressed as required. A REQUEST CAN NOT BE CONSIDERED IF INFORMATION PROVIDED IS INCOMPLETE, NON-RESPONSIVE, OR DOES NOT CLEARLY ADDRESS EACH OF THE REQUIREMENTS INDIVIDUALLY AS REQUIRED.			
RFS #	318.66-050		
STATE AGENCY NAME :	Department of Finance and Administration Bureau of TennCare		
SERVICE CAPTION :	Behavioral Health Organizations Providing Medically Necessary Behavioral Services to the TennCare/Medicaid Population in Tennessee East Grand Region		
CONTRACT #	FA-05-16089-00	**PROPOSED AMENDMENT #**	4
CONTRACTOR :	Tennessee Behavioral Health, Inc.		
CONTRACT START DATE :	07/01/2004		
CURRENT, LATEST POSSIBLE END DATE : (including ALL options to extend)	06/30/2006		
CURRENT MAXIMUM LIABILITY :	$326,044,256.00		
LATEST POSSIBLE END DATE WITH PROPOSED AMENDMENT : (including ALL options to extend)	06/30/2007		
TOTAL MAXIMUM COST WITH PROPOSED AMENDMENT : (including ALL options to extend)	$326,044,256.00		
APPROVAL CRITERIA : (select one)	☒ **use of Non-Competitive Negotiation is in the best interest of the state**		
	☐ **only one uniquely qualified service provider able to provide the service**		

ADDITIONAL REQUIRED REQUEST DETAILS BELOW (address each item immediately following the requirement text)

(1) description of the proposed additional service and amendment effects :

This amendment provides a mechanism for risk sharing, includes new Fraud and Abuse language as specified by the Office of Inspector General, establishes payment methodology that will continue throughout Fiscal Year 2006, as well as a variety of language clarifications.

(2) explanation of need for the proposed amendment :

This amendment is needed in order to establish payment mechanisms for remainder of FY '06 in order to continue behavioral health services for TennCare enrollees in addition to current language clarifications.

(3) name and address of the proposed contractor's principal owner(s) :
(not required if proposed contractor is a state education institution)

Dr. Russ Petrella, Chief Operating Officer
Magellan Behavioral Health
199 Pomeroy Road, 3rd Floor
Parsippany, New Jersey 07054

(4) documentation of OIR endorsement of the Non-Competitive procurement request :
(required only if the subject service involves information technology)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

(5) documentation of Department of Personnel endorsement of the Non-Competitive procurement request :
(required only if the subject service involves training for state employees)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

(6) description of procuring agency efforts to identify reasonable, competitive, procurement alternatives rather than to use non-competitive negotiation :

This contract for Behavioral Health Services was identified by a competitive Request for Proposal method. This amendment to the exisiting contract will ensure that services to recipients will continue without interruption and that payment rates are established for period to continue throughout FY '06.

(7) justification of why the F&A Commissioner should approve a Non-Competitive Amendment :

The approval of this amendment by F&A will ensure the best interests of TennCare enrollees will be served. Based on the network of providers that Tennessee Behavioral Health, Inc. currently has, TennCare is confident that the modifications of this agreement will ensure payment mechanism for remainder of FY '06 and prevent any disruption of services to enrollees.

AGENCY HEAD REQUEST SIGNATURE:
(must be signed by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR — signature by an authorized signatory will be accepted only in documented exigent circumstances)

SIGNATURE DATE:	

CONTRACT SUMMARY SHEET

RFS Number:	318.66-050	Contract Number:	FA-05-16089-04
State Agency:	Department of Finance and Administration	Division:	TennCare

Contractor			Contractor Identification Number
Tennessee Behavioral Health, Inc.	X	V-	621621636 01
		C-	

Service Description

Behavioral Health Services to Enrollees in the TennCare Partners Program in Tennessee East Grand Region

Contract Begin Date	Contract End Date
7/1/2004	6/30/2007

Allotment Code	Cost Center	Object Code	Fund		Grant	Grant Code	Subgrant Code
318.66	133	134	11		on STARS		

FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (include ALL amendments)
2005	$59,243,280.00	$108,632,276.00			$167,875,556.00
2006	$52,583,700.00	$94,277,700.00			$146,861,466.00
					$0.00
					$0.00
Total	$111,826,980.00	$202,909,976.00	$0.00	$0.00	$314,737,022.00

CFDA Number: 93.778 Department of Health and Human Services

State Fiscal Contact

Name: Scott Pierce

Address: 310 Great Circle Road

Phone: 615-507-6415

Procuring Agency Budget Officer Signature

Check the box (below) ONLY if the answer is YES	
Is the Contractor a SUBRECIPIENT? (per OMB A-133)	X
Is the Contractor a VENDOR? (per OMB A-133)	
Is the Fiscal Year Funding STRICTLY LIMITED?	
Is the Contractor on STARS?	
Is the Contractor's FORM W-9 ATTACHED?	
Is the Contractors Form W-9 Filed with Accounts?	

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

COMPLETE FOR ALL AMENDMENTS (only)

	Base Contract & Prior Amendments	This Amendment ONLY
End Date >	6/30/2006	6/30/2007
FY: 2005	$167,875,556.00	
FY: 2006	$146,861,466.00	
FY:		
FY:		
FY:		
FY:		$0.00
Totals:	$314,737,022.00	$0.00

AMENDMENT NUMBER 4

TO PROVIDER RISK CONTRACT #FA-05-16089

BETWEEN

THE STATE OF TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

AND

TENNESSEE BEHAVIORAL HEALTH, INC.
IN THE EAST GRAND REGION

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt of and sufficiency of which is hereby acknowledged, the parties agree to amend the Provider Risk Contract (Agreement) by and between the State of Tennessee Department of Mental Health and Developmental Disabilities, hereinafter referred to as **TDMHDD**, and Tennessee Behavioral Health, Inc., hereinafter referred to as the **CONTRACTOR**, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. **Emergency Mental Health and Substance Abuse Treatment Services - The third bullet in Section 2.5.5.5.3 shall be deleted in its entirety and replaced with the following:**

   If the **CONTRACTOR** and the treating physician cannot reach an agreement concerning the **Enrollee's** care and a physician representing the **CONTRACTOR** is not available for consultation. The treating physician shall continue with the continuity of care of the **Enrollee** until a physician representing the **CONTRACTOR** is reached or the **CONTRACTOR** attains at least one criteria detailed in this section to terminate the **CONTRACTORS** financial responsibility.

2. **Mental Health Case Management Section 2.5.6.10 shall be added and shall read as follows:**

   2.5.4.8 Abusive Utilizers of Pharmacy Services
   The TENNCARE PBM shall send information to TENNCARE and the OIG regarding lock-in candidates. Enrollees who disagree with such restrictions may appeal to TENNCARE pursuant to the medically necessary provisions of the TennCare hearing rules.

   The TENNCARE PBM shall provide a monthly report to the CONTRACTOR listing all enrollees identified for pharmacy lock-in. The CONTRACTOR shall use the

report to identify enrollees requiring case management.

3. A new Section 2.5.10 Retroactive Eligibility, shall be added as follows:

The **CONTRACTOR** shall be responsible for the payment of services during periods of retroactivity in the following circumstances:

1. The **CONTRACTOR** shall not be liable for the cost of any Behavioral Health Care services prior to the effective date of eligibility in the plan. However, the contractor shall be responsible for the costs of covered services obtained on or after 12:01am on the effective date of eligibility.

2. The **CONTRACTOR** shall include provisions governing the payment for medically necessary covered services provided to an enrollee by a non-contracted provider or non-referred provider for services received by an enrollee any time when TennCare determines that the enrollee is eligible for TennCare and has enrolled the individual in the CONTRACTORS plan and the enrollee could not have known which BHO they were enrolled in at the time of service.

3. The effective date of enrollment may occur prior to the BHO being notified of the enrollee becoming a member of the plan. When this situation arises, the BHO shall not deny medically necessary services provided during this period of eligibility for lack of prior authorization or lack of referral. Likewise, the **CONTRACTOR** shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which BHO the enrollee was enrolled in during the timely filing period. However, in such, cases the BHO may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

4. Requests for an informal review of denied emergency claims by TennCare and subsequent payment for covered services during a period of retroactive eligibility shall not be denied because of circumstances beyond a providers control such as the involvement of a third party payor.

4. A new Section 2.5.11 shall be added as follows:

2.5.11 Prior Authorization for Covered Services

2.5.11.1 General Rule

The **CONTRACTOR** and/or its sub-contractor's shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services, have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, and consult with the

requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR, sub-contractor's or an agent, payment for the pre-approved service shall not be denied based on the lack of medical necessity, assuming that the enrollee is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted. Prior authorization shall not be required for emergency services. Prior authorization requests shall be reviewed subject to the guidelines described in TennCare Rules 1200-13-13 and 1200-13-14 which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of a BHO to act timely upon a request. The CONTRACTOR must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of utilization management (UM) decision making. The CONTRACTOR must have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

2.5.11.2 At time of Enrollment

In the event an enrollee entering the BHOs plan is receiving medically necessary TennCare covered services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTORS provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR may require prior authorization for continuation of the services. Care rendered to a CONTRACTORS enrollee beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization need not be reimbursed.

2.5.11.3 Notice of Adverse Action Regarding Prior Authorization Requests

The CONTRACTOR must clearly document and communicate the reasons for each denial in a manner sufficient for the provider and enrollee to understand the denial and decide about appealing the decision. Notice of adverse actions to providers and enrollees regarding prior authorization requests shall be provided within the following guidelines:

(a) Provider Notice. The CONTRACTOR must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing; however, the CONTRACTOR must make a

reviewer available to discuss any denial decisions. Information provided to the provider must include how to contact the reviewer.

(b) Enrollee Notice. See notice provisions in TennCare Rules 1200-13-13-.11 and 1200-13-14-.11.

2.5.11.4 Appeals related to Prior Authorization Denials

If an enrollee appeals a prior authorization denial and the provider did not submit medical records to the CONTRACTOR as a part of the prior authorization determination process, upon request by TENNCARE, the CONTRACTOR shall go to the provider's office, if necessary, and obtain the medical records for TennCare's use in deciding the appeal.

Should a provider fail or refuse to respond to the CONTRACTORS request for information, including but not limited to, the request to provide medical records, and the appeal is decided in favor of the enrollee, at the CONTRACTORS discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

5. Section 3.1.12 Fraud and Abuse shall be deleted in its entirety and replaced with the following:

The Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the State Medicaid program (TennCare).

The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.

The **CONTRACTOR** shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The **CONTRACTOR** shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the **CONTRACTOR** in preventing and detecting potential fraud and abuse activities. Failure to comply with the fraud and abuse requirement set forth in this Agreement may result in liquidated damages as described in Section 5.3 of this Agreement.

3.1.12.1.1 The **CONTRACTOR** shall report all confirmed or suspected fraud and abuse to the appropriate agency as follows:

i. Fraud and abuse in the administration of the program. Suspected fraud and abuse in the administration of the program shall be reported to TBI MFCU and/or OIG.
ii. Provider Fraud and abuse. All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU.

iii. Enrollee fraud and abuse. All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG.

3.1.12.1.2 **CONTRACTOR** shall use the Fraud Reporting Forms attached to this Agreement, or such other forms as may be deemed satisfactory by the agency to which the report is to be made under the terms of this Agreement.

3.1.12.1.3 Pursuant to T.C.A. Section 71-5-2603(c), **CONTRACTOR** shall be subject to a civil penalty, to be imposed by OIG, for willful failure to report fraud by recipients, enrollees, applicants, or providers to OIG or TBI MFCU, as appropriate.

3.1.12.1.4 After reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, **CONTRACTOR** shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse, but shall not:

i. contact the subject of the investigation,
ii. enter into any settlement or agreement regarding the incident, or
iii. accept any money or other thing of value offered in connection with the incident unless prior approval is obtained from the agency to which the incident was reported, or to another agency designated by the agency that received the report.

3.1.12.1.5 The **CONTRACTOR** shall promptly provide the results of its preliminary investigation to the agency to which the incident was reported, or to another agency designated by the agency that received the report.

3.1.12.1.6 **CONTRACTOR** shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview **CONTRACTOR** employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

3.1.12.1.7 The State shall not transfer its law enforcement functions to the **CONTRACTOR.**

3.1.12.1.8 The **CONTRACTOR** and health care providers, whether participating or non-participating providers, shall, upon request and as required by this Agreement or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU/OIG shall, as required by this Agreement or state and/or federal law, be allowed access to the place of business and to all TennCare records of any **CONTRACTOR** or health care provider, whether participating or non-participating, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.

3.1.12.1.9 The **CONTRACTOR** shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, the provider must comply with Section 1-5 of this Agreement.

3.1.12.1.10 Except as described in Section 3.4.4.8 of this Agreement, nothing herein shall require the **CONTRACTOR** to assure non-participating providers are compliant with **TENNCARE** contracts or state and/or federal law.

3.1.12.2 Fraud and Abuse Compliance Plan

3.1.12.2.1 The **CONTRACTOR** shall have a written Fraud and Abuse compliance plan.

3.1.12.2.2 The fraud and abuse compliance plan shall:

i. Require that the reporting of suspected and/or confirmed fraud and abuse be done as required by this Agreement.

ii. Ensure that all officers, directors, managers and employees know and understand the provisions of the **CONTRACTORS** fraud and abuse compliance plan;

iii. Contain procedures to prevent and detect fraud and abuse in the administration and delivery of services under this contract:

iv. Include a description of the specific controls in place for prevention and detection of fraud and abuse, such as:

a. Claims edits;
b. Post-processing review of claims;
c. Provider profiling and credentialing;
d. Prior authorization;
e. Utilization management;
f. Relevant subcontractor and provider agreement provisions;
g. Written provider and enrollee material regarding fraud and abuse referrals.

v. Contain provisions for the confidential reporting of plan violations to the designated person as described in this Agreement;

vi. Contain provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;

vii. Ensure that the identities of individuals reporting violations of the plan or suspected fraud and abuse are protected and that there is no retaliation against such persons;

viii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

ix. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the OIG;

3.1.12.2.3 The **CONTRACTOR** shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (HHS OIG).

3.1.12.2.4 The **CONTRACTOR** shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

3.1.12.2.5 The **CONTRACTOR** shall submit an annual report to the Bureau of TennCare, Office of Contract Compliance and Performance, summarizing the results of its fraud and abuse compliance plan and other fraud and abuse prevention, detection, reporting, and investigation measures as required by section 1-9 of this Agreement. The report should cover results for the year ending June 30 and be submitted by September 30 each year. The information in this report shall be provided in accordance with and in a format as described in the **CONTRACTOR**S approved compliance plan.

6. Section 3.2.2 TennCare Cost Sharing for Services, shall be deleted in its entirety and replaced with the following:

3.2.2 Cost Sharing for Services

The **CONTRACTOR** and all of its contracted providers and sub-contractor's shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the BHO or non-payment by BHO. Furthermore, the **CONTRACTOR** and all providers and sub-contractors may not charge enrollees for missed appointments.

TennCare cost sharing responsibilities shall apply to services other than preventive services. The current cost share schedule to be used in determining applicable cost sharing responsibilities is included in this Agreement as Attachment III.

Effective for services provided on or after January 1, 2001, the **CONTRACTOR** shall be expressly prohibited from waiving or using any alternative TennCare cost sharing schedules, unless required by **TennCare**, regardless of whether or not the **CONTRACTOR** has been previously approved by **TennCare** to do so.

If, and at such time that TennCare amends any TennCare rules or regulations, including but not limited, to the TennCare cost sharing rules and regulations, the rules shall automatically be incorporated into this Agreement and become binding on the BHO and the BHOs providers.

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable TennCare cost sharing responsibilities for TennCare covered services, including but not limited to, services that the State or the BHO has not paid for except as permitted by TennCare rules and regulations 1200-13-13-.08, 1200-13-14-.08 and as described below. Providers may seek payment from an enrollee only in the following situations:

1. If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider is required to inform the enrollee on the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgement in writing prior to rendering service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills a BHO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

2. If the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills a BHO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

3. If the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost share amounts must be refunded when a claim is submitted to a BHO if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); or

4. If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:

   (a) The provider determines effective on the date of service that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and the service will not be paid for by TennCare. The source of the provider's information must be a database listed on the TennCare website as approved by TennCare on the date of the provider's inquiry;

   (b) The provider has information in his/her own records to support the fact that the enrollee has reached his/her benefit limit for the particular service being requested, and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by TennCare. This information may include:

      (i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect;

      (ii) That the provider had previously examined the database referenced in part 1. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect;

      (iii) That the provider had personally provided services to the enrollee in excess of his/her benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect.

(c) The provider submits a claim for service to the appropriate BHO and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. Then and thereafter, within the remainder of the period applicable to that benefit limit, the provider may continue to bill the enrollee for services within that same exhausted benefit category without having to submit, for repeated BHO denial, claims for those subsequent services.

(d) The provider had previously taken the steps in parts 1., 2., or 3. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by TennCare.

The **CONTRACTOR** shall require, as a condition of payment, that the service provider accept the amount paid by the **CONTRACTOR** or appropriate denial made by the **CONTRACTOR** (or, if applicable, payment by the **CONTRACTOR** that is supplementary to the enrollee's third party payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service. Should a provider, or a collection agency acting on the provider's behalf, bill an enrollee for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the enrollee, once a **CONTRACTOR** becomes aware the **CONTRACTOR** shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. After notification by the **CONTRACTOR**, if a provider continues to bill an enrollee, the **CONTRACTOR** shall refer the provider to the TBI MFCU.

7. Section 3.2.4 Out of Service Area and Out of Plan Use shall be amended by deleting Sections 3.2.4.1 and 3.2.4.2 in their entirety and replacing them with the following:

Section 3.2.4.1 - The CONTRACTORS plan shall include provisions governing utilization of and payment by the **CONTRACTOR** for emergency medical services received by an enrollee from non-contract providers, regardless of whether such emergency services are rendered within or outside the community service area covered by the plan. Coverage of emergency medical services shall not be subject to prior authorization by the **CONTRACTOR** and shall be consistent with federal requirements regarding post-stabilization services, including but not limited to, 42 CFR Section 438.114(c)(1)(ii)(A). Utilization of and payments to non-contract providers may, at the CONTRACTORS option, be limited to the treatment of emergency medical conditions, including post-stabilization care that includes medically necessary services rendered to the enrollee until such time as he/she can be safely transported to an appropriate contract service location. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TENNCARE rules and regulations for emergency out-of-plan services. Payment by

the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

Section 3.2.4.2 - The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Attachment A of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition herein and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTORS process and timeframes for reconsideration and subsequent steps regarding an informal review by TENNCARE. In the event a provider disagrees with the CONTRACTORS decision to disapprove a claim for emergency medical services, the provider may pursue the independent review process for disputed claims as provided by T.C.A. Section 56-32-226, including but not limited to, BHO reconsideration.

8. **Section 3.2.4.5 - A second Medicare paragraph shall be added as follows:**

The **CONTRACTOR** is responsible for coordinating **TennCare** covered benefits with benefits offered by other insurance, including Medicare, which the enrollee may have. For Medicaid eligible enrollees, such coordination must ensure that TennCare covered services are delivered without charge to the enrollee.

9. **Section 3.3 Appeal System Requirements shall be amended by deleting in its entirety and replacing with the following:**

3.3 Appeals and Complaints

(i) The enrollees shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, an appeal shall mean an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the enrollee or by a person authorized by the enrollee to do so, including but not limited to, a provider with the enrollee's written consent.

(ii) Complaint shall mean an enrollee's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall provide readable materials reviewed and approved by TENNCARE, informing enrollees of their complaint and appeal rights. The CONTRACTOR has internal complaint and appeal procedures for both TennCare Medicaid enrollees as well as TennCare Standard enrollees in accordance with TennCare rules

and regulations 1200-13-13-.11, 1200-13-14-.11 or any applicable TennCare rules and regulations, subsequent amendments, TennCare Waiver, or subsequent Court Orders governing the appeals process.

A portion of the regularly scheduled Quality Improvement meetings, shall be devoted to the review of enrollee complaints and appeals that have been received and resolved. The complaint and appeal procedures shall be governed by the following guidelines which are in accordance with TennCare policy as specified in TennCare rules and regulations and any and all Court Orders.

3.3.1 Appeals

The CONTRACTORS appeal process shall include, at a minimum, the following:

3.3.1.1 The CONTRACTOR shall have a contact person appointed at each service site. Said person shall be knowledgeable of appeal procedures and shall direct all appeals whether the appeal is verbal or in writing. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail to the designated P. O. Box for appeals related to the CONTRACTOR;

3.3.1.2 There shall be sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of Adverse Actions Affecting a TennCare Program Enrollee. Staff shall be knowledgeable about applicable state and federal law and all court orders governing appeal procedures, as they become effective. This shall include, but not be limited to, appointed staff members and phone numbers identified to TENNCARE where appropriate staff may be reached;

3.3.1.3 Staff shall be educated concerning the importance of the procedures and the rights of the enrollee and the timeframes in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal;

3.3.1.4 The appropriate individual or body within the plan having decision-making authority as part of the appeal procedure shall be identified;

3.3.1.5 The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Furthermore, appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, enrollees shall not be required to use an appeal form in order to file an appeal;

3.3.1.6 Upon request, the enrollee shall be provided a TENNCARE approved appeal form(s);

3.3.1.7 All appellants shall have the right to reasonable assistance by the CONTRACTOR during the appeal process;

3.3.1.8 At any point in the appeal process, TENNCARE shall have the authority to remove an enrollee from the CONTRACTORS plan when it is determined that such removal is in the best interest of the enrollee and TENNCARE;

3.3.1.9 The CONTRACTOR shall require providers to display notices of enrollee's right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. CONTRACTOR shall ensure that providers have accurate and adequate supply of public notices.

3.3.1.10 Except for initial reconsideration by a BHO, as permitted under the TennCare rules and regulations, no person who is an employee, agent or representative of a BHO may participate in deciding the outcome of a TennCare appeal. No state official may participate in deciding the outcome of a beneficiary's appeal who was directly involved in the initial determination of the action in question. The State will ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

- A denial appeal based on lack of medical necessity.
- A grievance regarding denial of expedited resolutions of an appeal.
- Any grievance or appeal involving clinical issues.

The CONTRACTOR shall keep a record of who reviews each reconsideration. The State will monitor compliance with this provision. Furthermore, for purposes of assuring timeliness and appropriateness of the provision of services a BHOs reconsideration to provide services shall be considered the same as a directive to do so by TENNCARE.

3.3.1.11 TENNCARE and/or the CONTRACTOR shall not prohibit or discourage any individual from testifying on behalf of an enrollee.

3.3.1.12 TENNCARE may develop additional appeal process guidelines and/or rules, including requirements as to content and timing of notices to enrollees, which shall be followed by the CONTRACTOR, if TENNCARE determines that it is in the best interest of the TennCare Program or if necessary to comply with federal or judicial requirements. However, CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional

guidelines or rules are stayed, reversed or otherwise rendered inapplicable, CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.

3.3.1.13 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof. Furthermore, provide for notice to providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and / or documentation described in section 3.12.15.

3.3.1.14 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as taking the initiative to seek prior authorization when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)

If it is determined by TENNCARE that violations of the appeal guidelines have occurred by the CONTRACTOR, TENNCARE shall require the CONTRACTOR to submit a corrective action plan. Failure to comply with the appeal guidelines issued by TENNCARE, including an acceptable corrective action plan, shall result in the CONTRACTOR being subject to liquidated damages as described in Section 5.3 of this Agreement.

10. Section 3.4.2 Enrollee Materials shall be amended by deleting the first two paragraphs and replacing with the following:

3.4.2 Enrollee Materials

The **CONTRACTOR** shall distribute various types of **Enrollee** materials to its entire service area as required by this CONTRACT. These materials include, but are not limited to, member handbooks, provider directories, identification cards, fact sheets, notices, or any other material necessary to provide information to **Enrollees** as described herein. The **CONTRACTOR** may distribute additional materials and information, other than those required by this Section, to **Enrollees** in order to promote health and/or educate **Enrollees**. These materials include, but are not limited to, newsletters, form letters, etc. The **CONTRACTOR** may make **Enrollee** and provider materials available via the Internet with the prior written approval of **TDMHDD**. However, all **Enrollee** materials must be approved by **TennCare** prior to distribution.

11. Section 3.4.2.1.1 Member Handbooks shall be amended by deleting in its entirety and replacing with the following:

The CONTRACTOR shall update or develop their member handbook annually

unless a longer period of time is approved by **TennCare and TDMHDD.** As described by **TennCare and TDMHDD,** the annual requirement to update and/or develop a member handbook may be delayed as the result of major modifications and/or reform efforts being implemented in the **TennCare** program. The **CONTRACTOR** must submit member handbooks for review and approval by **TennCare, TDMHDD and TDCI** at least thirty (30) calendar days prior to distribution. The **CONTRACTOR** must submit both English and Spanish language translations. Member handbooks must be distributed to Enrollees within thirty (30) calendar days of enrollment in the CONTRACTORS Plan. A member handbook must be distributed to all contracted providers upon initial credentialing and annually thereafter as handbooks are updated. The handbook shall, at a minimum, be in compliance with all applicable requirements of this Agreement and any and all federal and state laws, rules and regulations and include:

12. Section 3.4.2.1.5 shall be amended by deleting in its entirety and replacing with the following:

A description of **TennCare** cost sharing responsibilities for **Enrollees** must include an explanation that providers and/or the **CONTRACTOR** may utilize whatever legal actions that are available to collect these amounts. Furthermore, the information shall indicate that the enrollee may not be billed for covered services except for the amounts of the specified TennCare cost sharing responsibilities and of their right to appeal in the event that they are billed;

13. Section 3.4.2.1.15 shall be amended by deleting in its entirety and replacing with the following:

The toll-free telephone number for **TennCare** with a statement that the **Enrollee** may contact the plan or **TennCare** regarding questions about **TennCare**. The **TennCare** toll-free hotline number is **1-866-311- 4287;**

14. Section 3.4.2.2 Identification Card shall be amended by deleting in its entirety and replacing with the following:

Identification Card

Each enrollee shall be provided an identification card, which identifies the enrollee as a participant in the TennCare Partners Program within thirty (30) calendar days of notification of enrollment into the CONTRACTORS plan or prior to enrollee's beginning effective date. The identification card must comply with all state and federal requirements. Once the identification card has been approved by TENNCARE the CONTRACTOR shall submit five (5) printed sample cards of the final product, unless otherwise specified by TENNCARE, to the TennCare Marketing Coordinator within thirty (30) working days from the print date. Photo copies may not be submitted as a final product. Prior to modifying an approved identification card the CONTRACTOR shall submit for approval by

TENNCARE a detailed description of the proposed modification. The identification card may be issued by the CONTRACTOR, subject to prior approval of the format and content by TENNCARE, or the identification card may be issued by TENNCARE in a format and content mutually agreed upon by the CONTRACTOR and TENNCARE. Regardless of whether the identification card is issued by the CONTRACTOR or TENNCARE, all expenses associated with production and mailing of the identification card shall be the responsibility of the CONTRACTOR. Identification cards must be submitted to **TennCare, TDMHDD and TDCI** for prior approval.

15. Section 3.4.2.4.1 Quarterly Newsletters shall be amended by deleting in its entirety and replacing with the following:

Specific articles or other specific information as described by and requested by **TennCare and/or TDMHDD**. Such requests by **TennCare and/or TDMHDD** shall be limited to two hundred (200) words and shall be reasonable, including sufficient notification of information to be included;

16. Section 3.5 Staff Requirements shall be amended as follows:

Section 3.5.1.2.4 shall be deleted in it's entirely and replaced with the following:

Sufficient full-time clinical and support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, complying with the requirements related to fraud as set forth in Section 1.9 of this Agreement, prior authorizations, medical management, marketing, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews;

Section 3.5.1.2.9 shall be deleted in its entirety and replaced with the following:

A person who is trained and experienced in information systems, data processing and data reporting is required to provide necessary and timely reports to **TennCare and TDMHDD.**

Section 3.5.1.2.14 shall be deleted in its entirety and replaced with the following:

The **CONTRACTOR** shall identify in writing the Chief Executive Officer, Chief Financial Officer, Administrator, Medical Director, Title VI Compliance Officer, DCS liaisons and key contact person for Fraud Detection as set forth in Section 1.9 of this Agreement, Prior Authorizations, Marketing, Claims processing, Information Systems, Member Services, Provider Services, Appeal System Resolution, and EPSD&T within thirty (30) days of the CONTRACT execution. Notice of any changes in staff persons during the term of this CONTRACT must be made in writing within ten (10) business days.

17. Section 3.7.2, Provider Agreements. Sections 3.7.2.11, Section 3.7.2.13 and Section 3.7.2.41 shall be deleted in their entirety and replaced with the following:

3.7.2.11 Require that an adequate record system be maintained and that all records be maintained for no less than five (5) years from the close of the Agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions).

All agreements shall include a statement that as a condition of participation in TennCare, enrollees shall give the TENNCARE Bureau, TENNCARE, TDMHDD, the Office of the Comptroller, and any health oversight agency, such as OIG, TBI MFCU, HHS OIG, and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE, TDMHDD, or authorized federal, state and Comptroller personnel, including, but not limited to, the OIG, the TBI MFCU, the HHS OIG and the DOJ.

Require that medical records requirements found in Section 3.12.15 be included in provider agreements and that medical records are maintained at site where medical services are rendered. Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

The provider agreement must contain the language described in Sections 3.12.16 and 3.14.2 of this Agreement;

3.7.2.13 Provide that TENNCARE, TDMHDD, TDCI, HHS, HHS OIG ,Comptroller, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or

other means, any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of PHI to health oversight agencies, including, but not limited to, OIG, TBI MFCU, HHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, TDMHDD, TDCI, OIG, TBI MFCU, HHS OIG, DOJ, Office of the Comptroller, may use these records and information for administrative, civil or criminal investigations and prosecutions;

3.7.2.41 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider will comply with the appeal process, including but not limited to, the following:

1. assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review; and
2. require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)

18. Section 3.7.2 Provider Contracts. New Sections 3.7.2.52 and 3.7.2.53 shall be added:

3.7.2.52 Require the provider to comply with fraud and abuse requirements described in Section 1-9 of this Agreement;

3.7.2.53 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to, a provider's failure or refusal to respond to the CONTRACTORS request for information, the request to provide medical records, credentialing information, etc., at the CONTRACTORS discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

19. Section 3.9.2.1 Focused Clinical Studies. The first paragraph shall be deleted in its entirety and replaced with the following:

No later than April 1st of each calendar year, the **CONTRACTOR** shall submit to the **TDMHDD** Office of Managed Care, a written plan that identifies each of the proposed focused clinical study topics. On a quarterly basis, the **CONTRACTOR** shall provide progress reports on each focused clinical study and shall report annually on the results of each study no later than April 1st. Each study topic and its written plan must be submitted at least 3 months prior to the proposed implementation date for the study to the **TDMHDD** Office of Managed Care for review and approval. The written plans must include the following information:

20. Section 3.9.3.4 shall be amended by adding a second sentence that reads,

"Qualified mental health professionals rendering authorization decisions for the **CONTRACTOR** shall consult with the requesting providers when medically necessary."

21. Section 3.10.15 Availability of Records shall be deleted in its entirety and replaced with the following:

3.10.15 Availability of Records

3.10.15.1 The CONTRACTOR shall insure within its own organization and pursuant to any agreement the CONTRACTOR may have with any other providers of service, including, but not limited to providers, sub-contractor's or any person or entity receiving monies directly or indirectly by or through TennCare, that TENNCARE representatives and authorized federal, state and Comptroller personnel, including, but not limited to TENNCARE, the Office of the Inspector General (OIG), the Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU), the Department of Health and Human Services, Office of Inspector General (HHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to the medical care or services provided to TennCare enrollees.

3.10.15.2 The CONTRACTOR and its subcontractor's and any providers of service, including, but not limited to providers or any person or entity receiving monies, directly or indirectly, by or through TennCare shall make all records (including but not limited to, financial and medical records) available at the CONTRACTORS and/or the sub-contractor's expense for administrative, civil

and/or criminal review, audit, evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the HHS OIG, TENNCARE or any duly authorized state or federal agency. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. All records to be sent by mail will be sent to TENNCARE within twenty (20) working days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, TDMHDD, authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the HHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Agreement. Such requests made by TENNCARE shall not be unreasonable.

The CONTRACTOR and any of its sub-contractor's, providers any entity or person directly or indirectly receiving monies originating from TennCare, shall make all records, including, but not limited to, financial, administrative and medical records available to any duly authorized government agency, including but not limited to TENNCARE, OIG, TBI MFCU, HHS OIG and DOJ, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, TBI MFCU, HHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

3.10.15.3 The CONTRACTOR, any CONTRACTORS management company and any CONTRACTORS claims processing sub-contractor shall cooperate with the State, or any of the State's Contractors and agents, including, but not limited to TENNCARE, OIG, TBI MFCU, DOJ and the HHS OIG, and the Office of the Comptroller, and any duly authorized governmental agency, during the course of any claims processing, financial or operational examinations or during any administrative, civil or criminal investigation, hearing or prosecution. This cooperation shall include, but shall not be limited to the following:

3.10.15.3a Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or sub-contractor, to the State or any of the State's Contractors and agents, which includes, but is not limited to TennCare, OIG, TBI MFCU, DOJ and the HHS OIG, and the Office of the Comptroller and any duly

authorized governmental agency.

3.10.15.3.b Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives or any authorized entity of the state or federal government, and to cooperate fully with detail claims testing for claims processing system compliance.

3.10.15.3.c. Allowing for periodic review to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs have been incurred in accordance with this Agreement, including the requirement that provider reimbursement rates, reimbursement policies/procedures, medical management policies and procedures and Subcontractor arrangements remain in effect as they existed on April 16, 2002. The CONTRACTOR shall provide the auditor access to all information necessary to perform the examination.

3.10.15.3.d The CONTRACTOR shall cooperate fully with audits the State may conduct of medical management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified persons, or organization to conduct the audits.

22. A new Section 3.10.16 Medical Records Requirements, shall be added as follows:

The CONTRACTOR shall maintain, and shall require contracted providers and sub-contractor's to maintain medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Medical records are to be maintained at the site where medical services are provided for each member enrolled under this Agreement. The CONTRACTOR shall have policies and distribute policies to practice sites that address:

3.10.16.1. Confidentiality of medical records;
3.10.16.2 Medical record documentation standards;
3.10.16.3 An organized medical record keeping system and standards for the availability of medical records, including but not limited to:

(a) Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and subject to reasonable charges, be given copies thereof upon request;

(b) When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's

primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

3.10.16.4 Performance goals to assess the quality of medical record keeping; and

3.10.16.5 CONTRACTOR medical record keeping policies and practices must be consistent with 42 CFR 456 and NCQA Standards for medical record documentation.

3.10.16.6 CONTRACTOR must implement a Quality Monitoring Program Plan in accordance with TDMHDD requirements as referenced in Attachment C. The Quality Monitoring Program Plan must have prior written approval from TDMHDD.

23. A new Section 3.10.17 shall be added as follows:

3.10.17 30/60 Inpatient Report

The **CONTRACTOR** shall report quarterly to **TDMHDD** information on psychiatric inpatient facility services for the purpose of determining appropriate funding sources for lengthy hospitalizations. The report shall include **Enrollees** with a single paid inpatient stay greater than 30 calendar days and **Enrollees** with a total of 60 or more calendar days within a calendar year, regardless of the number of admissions. **TennCare** shall specify the time periods to be contained within the reports and the report format.

24. Section 3.11.6 Records Maintenance shall be deleted in its entirety and replaced with the following:

3.11.6 Records Maintenance

The CONTRACTOR and its providers, subcontractors and other entities receiving monies originating by or through TennCare shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section 1-9 of this Agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to TENNCARE, TDMHDD, OIG, TBI MFCU, DOJ and the HHS OIG, and Comptroller personnel during the Agreement period and five (5) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be

kept until all tasks or proceedings are completed. During the Agreement period, these records shall be available at the CONTRACTORS chosen location in Tennessee subject to the approval of TENNCARE and/or TDMHDD. If the records need to be sent to TENNCARE and/or TDMHDD, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR, subcontractor or provider records must be requested and approved by TDMHDD.

25. Section 3.12.5, Third Party Resources (TPL) shall be deleted in its entirety and replaced with the following:

3.12.5 Third Party Resources (TPL)

The CONTRACTOR shall be the payer of last resort for all covered mental health and substance abuse services in accordance with federal regulations. The CONTRACTOR shall exercise, full assigned benefit rights and/or subrogation rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Agreement and recover any such liability from the third party. The CONTRACTOR shall post all third party payments to claim level detail by enrollee. Unless otherwise indicated below, claims for which the CONTRACTORS files indicate TPL exists, but does not reflect third party payment shall be denied. Further, the CONTRACTOR shall report to TENNCARE any information regarding an enrollee's third party resources in a format and media as described by TENNCARE.

3.12.5.1 If the CONTRACTOR has determined that TPL exists for part or all of the services administered directly by the CONTRACTOR the CONTRACTOR shall make reasonable efforts to recover from third party liable sources the value of services rendered.

3.12.5.2 If the CONTRACTOR has determined that TPL exists for part or all of the services provided to an enrollee by a provider, the CONTRACTOR shall pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of TPL. The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE.

3.12.5.3 The CONTRACTOR may not withhold payment for services provided to an enrollee if TPL or the amount of liability cannot be determined, or payment will not be available within a reasonable time. Except for the claims described below, if the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR must reject the claim and return it to the provider for a determination of the amount of any third party payment. The claims exceptions are EPSDT, and all claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act. These claims will be paid at the

time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party. When the amount of payment is determined, the CONTRACTOR shall pay the claim at the rate allowed under the CONTRACTORS payment schedule. In no instance shall the amount of the third party payment and the CONTRACTORS payment exceed the provider's contracted TennCare rate.

3.12.5.4 All funds recovered from third parties will be treated as offsets to claims payments. The CONTRACTOR shall report all cost avoidance values to TENNCARE in accordance with federal guidelines and this Agreement.

3.12.5.5 TennCare Cost sharing responsibilities permitted pursuant to Section 3.2.2 of this Agreement shall not be considered third party resources for purposes of this requirement.

3.12.5.6 The CONTRACTOR shall provide third party resource (TPR) data to any provider having a claim denied by the CONTRACTOR based upon a TPR.

3.12.5.7 The CONTRACTOR shall provide any information necessary in a format and media described by TENNCARE and shall cooperate in any manner necessary, as requested by TENNCARE, with TENNCARE and/or a Cost Recovery Vendor at such time that TENNCARE acquires said services.

3.12.5.8 TPRs shall include subrogation recoveries. The CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be the property of the State. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.

3.12.5.9 The CONTRACTOR shall not make payment on a claim that has been denied by a third party payor when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc., unless otherwise directed by TENNCARE to do so.

3.12.5.10 TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTORS reported encounter data.

Should a TPL vendor collect TPL from the CONTRACTORS paid claims, the CONTRACTOR shall reimburse TENNCARE for the amount that TENNCARE owes the vendor on behalf of the recovered claim.

Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages as described in Section 5.3 of this Agreement. It shall be the CONTRACTORS responsibility to demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries. TENNCARE shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

26. The first paragraph of Section 4.7.2 Payment Methodology shall be amended to read as follows:

The **CONTRACTOR** shall be compensated based on the rates herein for the payment rate categories authorized by the State in a total amount not to exceed the **TennCare Partners Program** Maximum Liability established in Section 4.7.1. Payments shall be subject to withholds as set forth in the Agreement. The rates in Table 1 shall be applicable from August 1, 2005 through June 30, 2006.

27. Section 5.3.3.2 Deliverables shall be amended by adding five (5) additional deliverables & penalties to the end of the existing text as follows:

Item	Report	Referenced Section	Amount	Cure Period
5.3.3.2.34	Failure to seek, collect and/or report third party recoveries to TennCare.	Third Party 3.12.5	$500. per day for each calendar day that TennCare determines the CONTRACTOR is not making reasonable effort to seek and collect third party recoveries in addition to any administrative cost that TennCare incurs as the result of a TennCare Contracted vendor recovering TPL amounts.	None

5.3.3.2.35	Failure to obtain approval of marketing materials.	Marketing Materials, 3.4	$500. for each day that TennCare determines the CONTRACTOR has provided enrollee material that has not been approved by TennCare.	None
5.3.3.2.36	Failure to comply with marketing timeframes for providing Member Handbooks, I.D. cards, Provider Directories and Newsletters.	Marketing Materials, 3.4	$500. for each occurrence.	None
5.3.3.2.37	Failure to achieve and/or maintain financial reserves in accordance with TCA	Financial Requirements, 3.1.8	$500. per calendar day for each day that financial requirements have not been met.	None
5.3.3.2.38	Failure to comply with fraud and abuse provisions as described in Section 3.1.1.2 of this Agreement	Fraud and Abuse, 3.1.1.2	$500. per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions described in Section 3.1.1.2 of this Agreement.	None

28. The first sentence of Section 6.5 (2) Conflicts of Interest, shall be amended by adding the words "in writing" so that the amended sentence shall read:

"any State or federal employee or any immediate family member of a State or federal employee unless otherwise authorized **in writing** by the Commissioner, Tennessee Department of Finance and Administration.

29. Attachment A – Definitions is amended by adding new definitions for Office of Inspector General, TennCare Representatives, Tennessee Bureau of Investigation and Medicaid Fraud Control Unit (TBI MFCU and by deleting the definition for Program Integrity Unit and by deleting and replacing definitions State, TennCare, TennCare Standard Enrollee) so that the amended definitions shall read as follows:

Medical Records - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, medical services ordered for the member and medical services received by the member. All medical histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology

interpretations; physical therapy charts and notes; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.

Office of Inspector General (OIG) – The Office of Inspector General investigates and may prosecute civil and criminal fraud and abuse of the TennCare program or any other violations of state law, related to the operation of TennCare administratively, civilly or criminally.

State – The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Department of Finance and Administration, the Office of Inspector General, the Department of Mental Retardation, the Bureau of TennCare, the Medicaid Fraud Control Unit, the Department of Mental Health and Developmental Disabilities, the Department of Children's Services, the Department of Health, the TennCare Division within the Department of Commerce and Insurance and the Office of the Attorney General.

TennCare - The Program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare Representatives – The State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Agreement. Such entity(s) may include, but are not limited to, the TennCare Bureau, the Department of Health, the Department of Finance and Administration, the Department of Mental Health and Developmental Disabilities, the Department of Mental Retardation, the TennCare Division within the Tennessee Department of Commerce and Insurance, the Office of Inspector General and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.

TennCare Standard Enrollee – an enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as "TennCare Standard" as described in the approved TennCare waiver beginning on July 1, 2002, and as amended by CMS on March 24, 2005, and the TennCare Rules and Regulations.

Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The Tennessee Bureau of Investigation's Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program. The provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients' private funds in such facilities and allegations of fraud and abuse in board and care facilities.

30. Forms for reporting fraud and abuse shall be added as Attachment II of this contract (The documents are attached to the end of this Amendment).

31. Contract citations within the body of the contract shall be modified accordingly.

32. Any and all references to Program Integrity and/or Program Integrity Unit is herein changed and replaced in its entirety with the Office of Inspector General (OIG).

33. The first sentence of Section 6.20 Term of the Contract shall be deleted and replaced with the following:

The Contract shall remain in effect from July 1, 2004 through June 30, 2007 subject to receipt of necessary State approvals and receipt of approval from the United States Department of Health and Human Services.

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2006, or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

IN WITNESS WHEREOF, the parties have by there duly authorized representatives set their signature.

Russell C. Petrella, Ph.D. — DATE
President
Tennessee Behavioral Health, Inc.

TENNESSEE DEPARTMENT OF MENTAL
HEALTH AND DEVELOPMENTAL DISABILITIES

Virginia Trotter Betts, MSN, JD, RN, FAAN — DATE
Commissioner

TENNESSEE DEPARTMENT OF
FINANCE AND ADMINISTRATION:

M.D. Goetz, Jr. — DATE
Commissioner

APPROVED:

TENNESSEE DEPARTMENT OF
FINANCE AND ADMINISTRATION:

M.D. Goetz, Jr. — DATE
Commissioner

COMPTROLLER OF TREASURY:

John G. Morgan — DATE
Comptroller of Treasury

TENNESSEE BUREAU OF INVESTIGATION

MEDICAID FRAUD CONTROL UNIT

FRAUD ALLEGATION REFERRAL FORM

DATE: _____

1 **TO (CIRCLE RECIPIENT): SAC BOB SCHLAFLY** [*FAX (615) 744-4659]*
ASAC Stephen Phelps [*fax (731) 668-9769]*
ASAC Norman Tidwell [*fax (615) 744-4659]*

FROM: _____ **(TennCare CONTRACTOR)**

Contact Person: _____
Telephone: _____
E-Mail: _____

SUBJECT NAME: _____ **d/b/a** _____
SUBJECT ADDRESS: _____ _____
_____ _____
_____
_____

PROVIDER NUMBER(S): _____
_____
_____

SUMMARY OF COMPLAINT: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ADDITIONAL SUBJECT INFORMATION: _____
_____
_____
_____

REPORT TENNCARE RECIPIENT FRAUD OR ABUSE

Date:

Please complete as much information as possible.

Name of Recipient/Person you are Reporting fraud — recipient name or name of individual suspected of

Other Names Used (If known) — alias

Social Security Number (If known)

Date of Birth

Children's Name (if applicable) — SSN, if known — DOB, if known

SSN, if known — DOB, if known

Spouse's Name (if applicable)

Street Address — physical address

Apartment #

City, State, Zip — city state zip

Other Addresses Used

Home Phone Number
area code

Work Phone Number (Please include)
area code

Employer's Name

Employer's Address

Employer's Phone #
area code

What is your complaint? (In your own words, explain the problem)describe suspected fraudulent behavior

Have you notified the Managed Care CONTRACTOR of this problem? ☐ Yes ☐ No

Who did you notify? (Please provide name and phone number, if known)name phone number dept/ business

Have you notified anyone else? ☐ No ☐ Yes name phone dept/ business

Requesting Drug Profile ☐ Yes ☐ No Have already received drug profile ☐ Yes ☐ No

If you are already working with a PID staff person, who?

***Please attach any records of proof that may be needed to complete the initial review.**

OIG/CID Investigator: your name

Phone number

STATE OF TENNESSEE
OFFICE OF TENNCARE INSPECTOR GENERAL
PO BOX 282368
NASHVILLE, TENNESSEE 37228
1.1.1.1.1 FRAUD TOLL FREE HOTLINE 1-800-433-3982 • FAX (615) 256-3852
E-Mail Address: www.tennessee.gov/TennCare (follow the prompts that read "Re

41. All references in the Contract to "Program Integrity Unit" shall be deleted and replaced with "Office of Inspector General".